APPEAL NO. 93471

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1993). On September 10, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine issues relating to the correct impairment rating resulting from a cervical spine injury sustained by the claimant,. The Appeals Panel reversed the decision and remanded the case for further consideration and development of the evidence. A hearing on remand was held on March 17, 1993, after one continuance. The presiding hearing officer on remand was (hearing officer), who adopted the determination of the designated doctor, finding that claimant reached maximum medical improvement on June 5, 1992, with a seven percent impairment.

The claimant has appealed this decision, urging that the great weight of other medical evidence is contrary to the report of the designated doctor. The carrier responds that the decision should be affirmed.

DECISION

After reviewing the record of the case, we affirm the hearing officer's decision.

In this case, the claimant, who was employed by (employer), sustained an injury to his cervical spinal area while lifting equipment in the course and scope of his employment on October 8, 1991. The claimant lost six weeks of work but returned to employment under certain restrictions from his treating doctor, (Dr. S).

The other medical evidence, set out in more detail in the first Appeals Panel decision, Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992, will be briefly summarized again.

Claimant was first treated for his injury on October 9, 1991, by (Dr. M), who prescribed a cervical collar and pain killers. An October 16, 1991, MRI conclusion was: "1. Small central and left paramedian disc bulge is at the C4-5 and at the C6-7 disc space levels. 2. The most impressive abnormality is that of a moderate central and right paramedian subligamentous C5-6 disc herniation."

Dr. M referred the claimant to (Dr. E), a neurologist, who in his notes of an October 29, 1991, examination described some pain, claimant's complaints of some intermittent numbness in his fingers occurring primarily in the right hand, no weakness in hand grip or proximal muscles in upper extremity, restriction to 60% of normal in the cervical range of motion, a C5-6 disc herniation with some nerve encroachment, and right C6 radiculopathy with mild thecal sac compression.

Dr. E referred claimant to (Dr. N), a neurological surgeon. Dr. N noted complaints of intermittent tingling in some fingers of the right hand, but notes that the remainder of his sensory examination is normal. Range of motion of the neck was decreased by 30%.

Upon review of the MRI, Dr. N recommended continuation of conservative treatment "before definitely deciding on his need for disc removal at C5-6."

The claimant then selected (Dr. S), an orthopedic surgeon, for a second opinion as to whether he needed surgery. Dr. S became claimant's treating doctor. On March 31, 1992, Dr. S certified MMI, and assessed an impairment of 18%. He stated that he calculated this based upon six percent for each injured disc, using page 73 (Table 49) of the AMA Guides to the Evaluation of Permanent Impairment (Guides).

However, Dr. S subsequently changed his impairment rating and the theory upon which it was calculated. In a second TWCC-69 report, Dr. S certified MMI effective July 17, 1992, with a 23% impairment. Dr. S's accompanying letter indicated that the new rating considered the results of an EMG that was conducted July 9, 1992, which appeared to indicate that there was some sensory loss involving the C5, C6, and C7 motor fibers. Dr. S stated that, for purposes of using Table 49, "the problem seen at the three levels on the MRI could be interpreted as a cervical segment; therefore, being only 6% rather than the previously estimated 18%." He stated that he used Table 12, on page 41, (entitled Unilateral Spinal Nerve Root Impairment Affecting the Upper Extremity) to derive further impairment percentages for C-5 of five percent, C-6 of eight percent, and C-7 of five percent relating to the cervical radiculopathy. His report stated that he then used the Combined Value Table to derive the whole body impairment yielded by both discreet impairment measurements.

Upon dispute by the insurance carrier with Dr. S's first TWCC-69, the Commission appointed (Dr. A) as designated doctor. Dr. A examined claimant on June 5, 1992, and determined that he reached MMI effective that date, with a seven percent rating. Dr. A's report noted the medications being taken by the claimant, stated no evidence of muscle spasm or tenderness on palpation of the neck, normal range of motion of the cervical spine, with perhaps a slight restriction to extension only, and complaints of intermittent pain, tingling, and loss of sensation on some fingers of the right hand (not present all the time). Dr. A stated: "I was unable to elicit any motor or sensory loss of either upper extremity." Dr. A indicated that he evaluated previous tests and doctors' records. He stated that he agreed with a diagnosis of disc herniation of the C5-C6 level "with some spondylosis" and also a small herniation of the C6-7 level. He agreed with non-surgical treatment.

Dr. A stated that he rendered his impairment rating using Table 49. During remand, in which it was specifically required that Dr. A consider the EMG testing, Dr. A stated in answer to deposition on written questions that he did not regard the test itself as diagnostic of radiculopathy in the absence of clinical signs of same. Because he found no clinical signs, Dr. A stated that he deemed EMG evidence of radiculopathy as only transient. He stated his opinion was unchanged by his review of the EMG. In another answer on the same deposition, Dr. A stated that he did not recall how long claimant's examination lasted.

The difference between the opinions of Dr. S and Dr. A, after Dr. S's second certification, was not as to the use of Table 49 but rather the assessment of impairment relating to the purported radiculopathy. Because part of the claimant's appeal questions whether Dr. A has correctly calculated impairment from Table 49, we emphasize that Dr. S in his second TWCC-69 "came around" to Dr. A's philosophy for calculating the physical impairment from Table 49. In fact, Dr. A's use of Table 49 is more favorable to claimant by one percent.

As the claimant is aware, the report of a Commission-appointed designated doctor is given presumptive weight. Article 8308-4.26(g). Only the great weight of medical evidence can reverse this presumptive status. Claimant has presented medical evidence as well as his own testimony. However, the amount of evidence needed to overcome the presumption must be that of "great weight," which is more than a preponderance, and calls for a hearing officer to do more than balance the two opinions. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. The hearing officer was not convinced that Dr. S's opinion overcame Dr. A's assessment or other doctor's opinions indicating only some intermittent numbness.

The decision of the hearing officer to accord presumptive weight to the designated doctor's opinion is sufficiently supported by the evidence, and his decision is affirmed.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Philip F. O'Neill
Appeals Judge